Washington State Department of Social & Health Services

AGING AND ADULT SERVICES

RESPITE CARE REASSESSMENT/TERMINATION

TYPE OF CONTACT ☐ Telephone ☐ In person

CONTACT DATE(S) MO DAY YR MO DAY YR

CAREGIVER'S NAME	SOCIAL SECURITY NUMBER	LAST ASSESSMENT DATE

PARTICPANT'S NAME	SOCIAL SECURITY NUMBER

Caregiver/participant wants to continue with respite care? ☐ YES ☐ NO

If yes, reassess through in-home visit.
If no, fill out Section B.

A. ASSESSMENT CHANGES

REASSESSMENT TYPE: ☐ Annual Review ☐ Change in Situation

Assessment changes: Identify below the section where the item response(s) has/have changed since the last assessment or reassessment. Enter the number(s) of the changed item(s) for each section in the space provided.

Complete these items on the appropriate page of assessment and attach the revised page(s) to this cover sheet. File with previous assessment. Enter "None" if no items in a given section were changed.

PARTICIPANT INFORMATION FROM THE COMPREHENSIVE ASSESSMENT, DSHS 14-327

Section	Items Changed
I	
II	
III	
IV	
V	

CAREGIVER INFORMATION FROM THE RESPITE CAREGIVER ASSESSMENT, DSHS 14-340

Section	Items Changed
I	
II	
III	

SERVICE PLAN CHANGES: ☐ YES ☐ NO

If yes, write service plan changes on a new service plan form and file with current service plan.

B. TERMINATION

Date: MO DAY YR

Indicate reason:

☐ Death ☐ Moved out-of-state ☐ Refused services
☐ No longer eligible ☐ Lost contact ☐ Moved to nursing home
☐ Other (specify) _____

CASE MANAGER'S SIGNATURE	TELEPHONE	OFFICE ID	WORKER ID